Could a National Long-Term Care Insurance Program be a Feasible Solution to Address Canada's Growing Long-Term Care Crisis?

Lessons from Six Countries

AGEING IN THE *RIGHT* PLACE

NIA NATIONAL INSTITUTE ON AGEING

May 2023

National Institute on Ageing

Suggested Citation:
C Fell, BC Yoon, A Arulnamby, SK Sinha. Could a National Long-Term Care Insurance Program be a Feasible Solution to Address Canada's Growing Long-Term Care Crisis? Lessons from Six Countries. Toronto: ON: National Institute on Ageing (2023), Toronto Metropolitan University.

ISBN: 978-1-77417-062-5

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Table of Contents

About the National Institute on Ageing

The National Institute on Ageing (NIA) is a public policy and research centre based at Toronto Metropolitan University (formerly Ryerson University). The NIA is dedicated to enhancing successful ageing across the life course. It is unique in its mandate to consider ageing issues from a broad range of perspectives, including those of financial, psychological, and social well-being.

The NIA is focused on leading cross-disciplinary, evidence-based, and actionable research to provide a blueprint for better public policy and practices needed to address the multiple challenges and opportunities presented by Canada's ageing population.

The NIA is committed to providing national leadership and public education to productively and collaboratively work with all levels of government, private and public sector partners, academic institutions, ageing related organizations, and Canadians.

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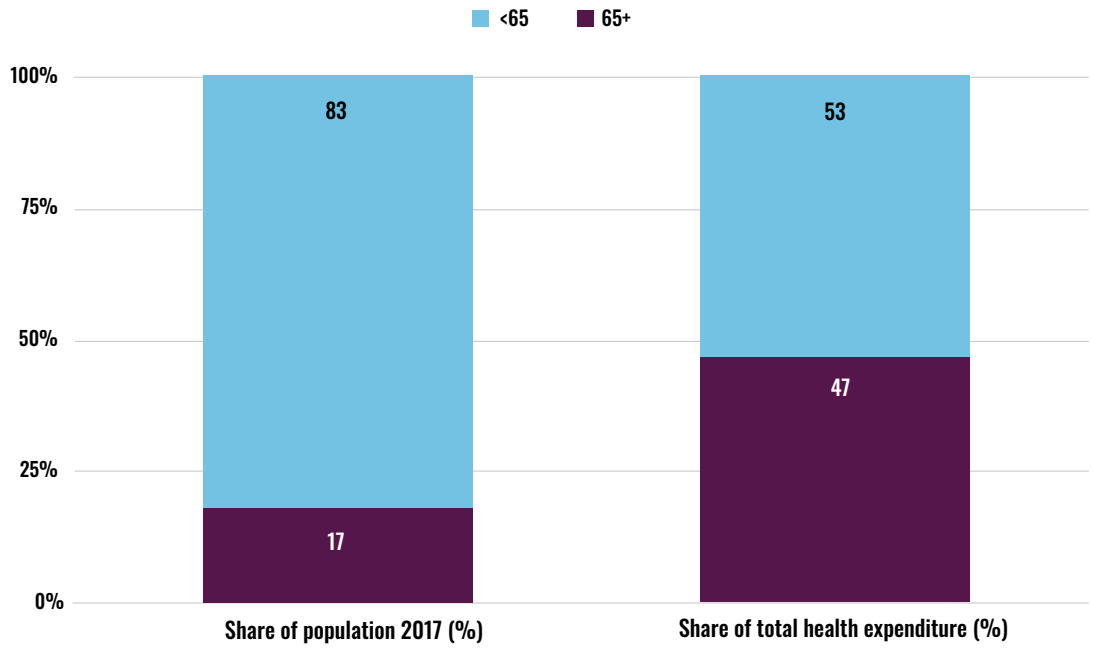
Introduction

Canada is rapidly transitioning into a "super-aged society," a country where at least 21% of its population is aged 65 years and older.[1] In 2016, the number of adults aged 65 years and older began to outnumber people 15 years and younger for the first time.[2] As of 2021, there were a total of seven million adults aged 65 years and older, nearly one fifth (19%) of Canada's population, with over 861,000 Canadians aged 85 years and older.[3] Canada is on track to become a "super-aged society" within the next few years, and by 2048, Canadians aged 65 years and older are expected to comprise upwards of 26.6% of the total population,[4] while the number of Canadians aged 85 years and older are expected to triple to an estimated 2.3 to 2.8 million people over the same time period.[5]

Canadians are also living healthier and longer lives than ever before. In 2020, life expectancy at birth increased from 71 years in 1960 to 82 years. Canadians can also expect to live an additional 22 years after reaching the age of 65.[6] Health adjusted life expectancy (HALE) adjusts for the number of healthy years one can expect to live given the current morbidity and mortality conditions. Statistics Canada released the most recent HALE measures in 2017; the average Canadian can expect to live 71.4 years in good health, compared to 68.5 years in 2000. Moreover, at age 65, Canadians can expect to live an additional 15.4 years in good health compared to 13.4 years in 2000.[7]

Ageing populations present social, economic and political challenges. Among these, older adults utilize health care and social services more compared to their younger counterparts. The combination of the increasing number of older adults and the increased demand associated with population ageing will continue to challenge the fiscal capacity of the government to provide publicly-funded health care and social services. For example, while Canadians aged 65 years and older now comprise nearly one fifth (19%) of Canada's total population,[8] in 2017, they already accounted for almost half (47%) of all health care spending (see figure below). In per capita health expenditures, public spending on health care for older adults is $12,000 per year, compared to $2,700 for adults aged 64 years and younger.[9]

Figure 1: Proportion of Canadian Population Aged 65 Years and Older Compared to Health Expenditures in 2017



From Meeting the Care Needs of Canada's Aging Population—July 2018, R. Gibbard, 2018, The Conference Board of Canada. (https://www.cma.ca/sites/default/files/2018-11/Conference%20Board%20of%20Canada%20-%20Meeting%20the%20Care%20Needs%20of%20Canada%27s%20Aging%20Population%20%281%29.PDF). Copyright 2018 by The Conference Board of Canada.

Older Canadians also account for greater public and private expenditures through the provision of long-term care (LTC) services in private dwellings or in LTC homes. The National Institute on Ageing (NIA) estimated that, in 2019, $22 billion was being spent on the provision of publicly-funded LTC annually for older Canadians through the provision of home care and LTC home-based care, and projects this figure to more than *triple* by 2050, increasing to an estimated $71 billion, in today's dollars.[10]

However, not all adults with complex care needs will require LTC home-based care. Recent estimates by the Canadian Institutes of Health Information (CIHI) have suggested that approximately 10% of older adults being admitted to LTC homes across Canada could potentially have remained at home and in their communities if adequate home and community care were made available.[11,12]

The NIA's Report *Bringing Long-Term Care Home* (2020) found that the Ontario government could further save between an average of $212,259 and $268,369 in infrastructure costs alone for every LTC home bed it may no longer need to build or redevelop by better meeting the needs of its ageing population to "age in place."[13] Furthermore, according to the Ontario Ministry of Health (MOH) in 2021-22, it supported more than 131,180 LTC home eligible clients of all ages to live in their own homes, which included more than 97,700 clients who were 75 years of age and older.[i] The MOH further estimated that in 2021-22, the home care costs to support the more than 131,180 LTC home eligible home care clients was close to $1.3 billion.[ii] This is only a fraction of the projected $6.4 billion the Ministry of Long-Term Care (MLTC) will be spending for its close to 79,000 publicly-funded LTC home beds in 2021-22.[14] While over 52,000 Canadians are on waiting lists for placement into a LTC home,[15] over 430,000 adult Canadians have been estimated to have unmet home care needs, with 167,100 of them being 65 years of age and older.[16] There is, therefore, a clear opportunity to limit overall LTC expenditures by supporting more people to receive the care equivalent to what they would receive in an LTC home setting in their own homes, especially when the demand for home care services in Canada is expected to increase by 120% between now and 2050.[17]

Canada's LTC sector is hindered by underfunding and a limited supply of trained health care providers. The COVID-19 pandemic disproportionately affected LTC homes in Canada. During the first and second pandemic waves, there were more than 56,000 cases of COVID-19 and 14,000 deaths due to COVID-19 among residents of LTC and retirement homes. Between March and August 2020, LTC and retirement home residents accounted for 67% of all COVID-19 related deaths in Canada.[18] As of July 1st, 2022, 43% of all COVID-19 deaths in Canada have occurred in LTC and retirement home settings.[19]

[i] C. Martineau (personal communication, July 20, 2022) noted that data was from Client Health and Related Information System (CHRIS) client information system. Data was pulled on July 20, 2022 through the Ontario Health HCC Information Program team in collaboration with Home and Community Care Support Services (HCCSS) Decision Support. Criteria Used: LTC eligible clients identified as patients with admitted to homecare services where through an interRAI-HC assessment, their MAPLe score was either 4 or 5 (High or Very High appropriateness for LTC home)

[ii] C. Martineau (personal communication, July 20, 2022) noted that data was from CHRIS client information system. Data was pulled on July 20, 2022 through the Ontario Health HCC Information Program team in collaboration with HCCSS Decision Support. Criteria Used: LTC eligible clients identified as patients with admitted to homecare services where through an interRAI-HC assessment, their MAPLe score was either 4 or 5 (High or Very High appropriateness for LTC home)

Part 1: An Overview of Canada's LTC Systems

Canada does not have a consensus definition of LTC. The NIA defines LTC as "a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided by either not-for-profit and for-profit providers, or unpaid caregivers in settings that are not location specific and thus include designated buildings, or in home and community-based settings." LTC services, therefore, can consist of a mix of services and be delivered by either public or private care providers across a range of settings, including in institutions, the community and individuals' homes.

The Canada Health Act aims "to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such service."[20] LTC services, however, are not covered under the CHA. Thus, Canada's LTC system is a "patchwork" of provincial, territorial and federal policies and programs that results in varying levels of eligibility, service coverage and financial protection.[21] In 2016, an estimated 709,500 Canadians aged 65 years and older received some form of LTC,[22,23] equivalent to 12.0% of all older adults.[24] Within this group, over 198,000 older adults received care in LTC homes[iii,25] and approximately 511,500 older adults received care from home and community care providers.[26]

Based on the latest census data, an estimated 205,000 older adults received care in LTC homes in 2021.[27] Even though more recent estimates of older Canadians receiving home care is not available, provincial figures suggest that the number has increased from around 511,500 in 2016. For example, it was reported in 2021-22 that Ontario's home care system alone is providing care to more than 449,380 older adults every year.[iv]

[iii] Those receiving care in designated LTC buildings includes: nursing homes and half those reported as receiving care in facilities that are a mix of both a nursing home and a residence for seniors citizens.

[iv] C. Martineau (personal communication, July 20, 2022) noted that data was from MIS Comparative Reports. The data was pulled on July 20, 2022 through the Ontario Health HCC Information Program team in collaboration with HCCSS Decision Support. Criteria Used: MIS category of Elderly (65+ years of age).

The majority of Canadians pay for their LTC through a combination of public subsidies and out-of-pocket payments. Recent figures found that 52% of Canadians received home care services solely through publicly-funded sources. In comparison, 27% of home care recipients paid for their services strictly out-of-pocket.[28] The costs of purchasing home care services are also becoming increasingly unaffordable. The estimated costs of purchasing private in-home care services can range from $1,000 to $3,500 dollars per month.[29] In Ontario, the costs of home care for clients with complex care needs can reach up to $25,000 per month.[30]

Many home care and LTC home care recipients require additional care beyond the coverage provided by public subsidies and out-of-pocket payments. Unmet care needs are commonly addressed by unpaid family caregivers. Family caregivers are constantly considering the economic, social and health-related costs of providing care. Based on the demographic projections and the corresponding increase in demand for LTC services, the NIA estimates that the unpaid family caregivers' labour would need to increase between now and 2050 by 40% to keep up with the growing care needs of older Canadians.[31] In addition to needing to do more on average, many more workers will be called on as unpaid caregivers as the number of older Canadians needing support more than doubles over this period. The NIA also estimates that, if all unpaid hours of care being provided inside people's own homes were instead paid publicly, it would add an additional $27 billion in public costs by 2050, in today's dollars.[32]

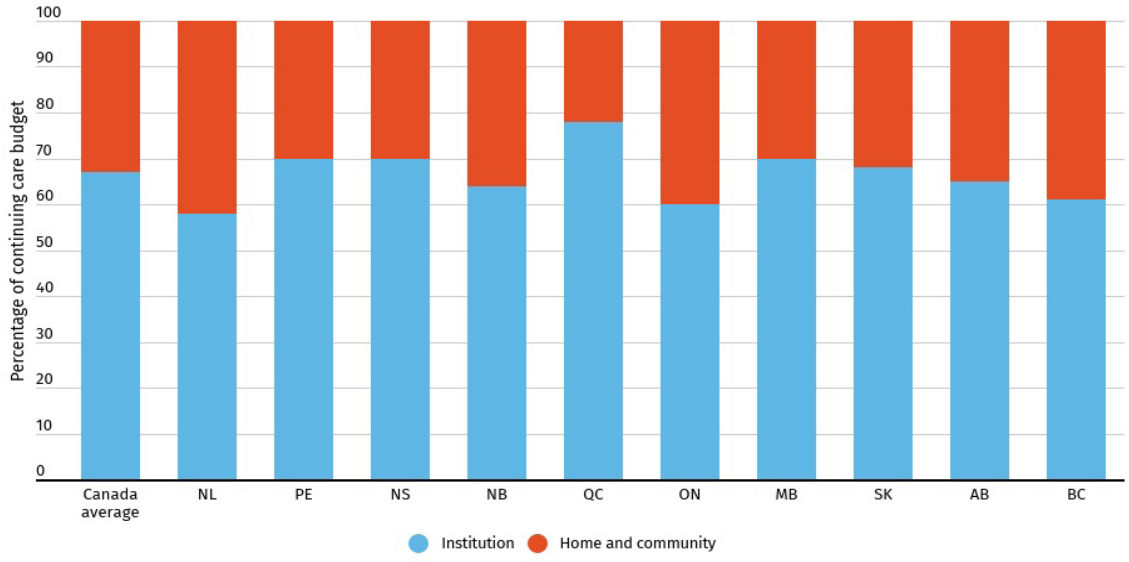
The Organisation of Economic Cooperation and Development (OECD) estimated that, while in 2019, Canada spent 2.0% of its Gross Domestic Product (GDP) on LTC services, almost 25% above the OECD average of 1.5%, this remained well below at least 10 other countries like the Netherlands, Denmark, Germany and Japan — that spent up to 4.1% of their GDP on the provision of LTC services.[33] Additionally, although from 2005 to 2015, Canada's LTC expenditures grew at a rate of 2% annually, it was far below the OECD average of 4.6%.[34]

How Canada allocates its LTC expenditures is also comparably different compared to other OECD countries. OECD countries spent an average of 52% of their LTC spending providing care in LTC homes, whereas Canada spends 64% of its spending doing so in 2019. Among countries reporting above-average spending on care in LTC homes, Canada also reported the second-largest allocation of its LTC spending, at 15%, on providing this care in its hospitals versus an OECD average of 9%.[35] Canada's hospital-based LTC spending is attributed to its Alternate Level of Care (ALC) patients – i.e. patients who are waiting in

hospitals principally to access LTC services in their own private-dwellings or in LTC homes. With respect to the provision of home and community care, however, the average OECD country allocates 36% of their LTC spending on this compared to only 18% in Canada.[36]

The CIHI's National Health Expenditure Database more recently estimated that in 2020, 33% of Canadian LTC funding is allocated to home and community care and the remaining 67% is allocated to care in LTC homes. The allocation of LTC expenditure to community and LTC home care varied across provinces, with Quebec (78%) allocating the largest share and Newfoundland (58%) allocating the lowest share of their LTC expenditure to LTC home care.[37] Figure 2 displays Canada's national and provincial allocations of LTC expenditure during the 2020-2021 period.[38]

Figure 2: Home and Community Care vs LTC Home-based Care[1] Spending in Canada (2020-2021)



Source: CIHI NHEX (2021) and author's calculations.

[1] CIHI reports spending on "Other Institutions," which is comprised mostly of spending on residential care for the aged (nursing homes), but also includes facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, and alcohol and drug problems; and facilities for emotionally disturbed children.

From Home Care Spending Data are a Launching Point for Better Policies, C. Busby, 2021, Policy Options. (https://policyoptions.irpp.org/magazines/november-2021/home-care-spending-data-are-a-launching-point-for-better-policies/). Copyright n.d. by Policy Options.

The COVID-19 pandemic has initiated economic shocks globally, raising concerns about future public spending. During the 1990s and early 2000s, health spending outpaced GDP growth across most OECD countries, including Canada. After the 2008 economic crisis, health care spending across OECD countries dropped dramatically, but gradually rose to pre-crisis levels over several years. Across the European Union, the 2008 economic crisis resulted in austerity, with countries cutting spending on health, tightening control on health expenditures and dropping service coverage, resulting in higher levels of unmet need for health care and an increase in catastrophic health expenditures.[39]

During the COVID-19 pandemic, GDP rapidly declined, while health care spending increased dramatically as governments responded to the pandemic. Continuous spending on health care, however, may require governments to re-allocate funds away from LTC expenditures, especially as hospitals, drugs and physicians continue to account for the largest share of health spending.[40] Economic shocks, such as the ones imposed by COVID-19, further impact caregiving and the provision of LTC in specific ways. Recessions result in significant job losses and lower public revenue, leading to higher levels of unpaid caregiving, a lower ability to pay for care, and the tightening of public budgets supporting the provision of LTC.[41]

What is Long-Term Care Insurance?

Canadians are ineligible to receive LTC services under the CHA. As a result, Canada's LTC systems are largely provincially and territorially governed but also fragmented as significant gaps exist in what is provided and at what cost to the user. These challenges have become most evident by the growing reported high levels of unmet need and increasing out-of-pocket costs associated with the provision of LTC in Canada. Indeed, currently 52,000 Canadians are on wait-lists for placement into a LTC home,[42] while over 432,000 adult Canadians have been estimated to have unmet home care needs.[43] Among the latter group, over 167,000 were aged 65 years and older.[44] Furthermore, the estimated cost of private in-home care services can range from $1,000 to $3,500 per month,[45] with 27% of home care recipients paying for these services entirely through out-of-pocket payments.[46] In 2019, despite Canada's governments spending approximately $38 billion on publicly-funded LTC health services, Canadian households spent an additional $9.4 billion on out-of-pocket payments to access LTC health services.[47]

Private LTC insurance is also an option for Canadians, although the sustainability and affordability of such programs are challenging due to adverse selection which leads to market failure. In other words,

private insurers struggle to offer affordable LTC insurance premiums because of the small selection pool and high probability that the insured will require services. The small selection pools have, therefore, forced insurers to raise their premiums, making private insurance even more unaffordable and further decreasing the potential selection pool. This is evident from the fact that only 7% of home care recipients of all ages have services covered solely by insurance, with another 8% of recipients of all ages having services partly covered by insurance and/or government funding.[48]

A potential solution to address many of these growing challenges in Canada would be the development of a public Long-Term Care Insurance (LTCI) program. A number of international jurisdictions have created such programs over the past few decades. Such a program would collect revenue from a large population pool, preferably a national population, thus re-distributing the potential future risks and costs of needing LTC services across a larger population. Collecting premiums from a national population therefore increases the financial protection of individuals by subsidizing the risk of high LTC utilizers against the risk of low LTC utilizers, leading to a more sustainable financing mechanism and more equitable access to LTC services.

The NIA has chosen to spotlight six international jurisdictions with established public LTCI programs: Japan, Germany, South Korea, Taiwan, the Netherlands and Washington State. These programs illustrate that there is no "one size fits all" approach to planning a LTCI program. The LTCI programs the NIA examined in each country are financed through a varying combination of taxation, social contributions and out-of-pocket spending requirements. Each LTCI program varies in their levels of eligibility, the benefits provided, the level of user choice and the level of individual financial protection offered.

This report aims to illustrate the key features and characteristics of each country's LTCI programs and discuss their potential application to the Canadian context. Each case study contains a brief overview of the historical context and aims of the LTCI program; the eligibility of its recipients and benefits provided; and the governance structure and organizational responsibilities and the financing arrangements associated with each program. The final section of the report presents an analysis of ways in which the characteristics and lessons learned from the international case studies could be adapted to the Canadian context.

Part 2: Six Case Studies of Public LTCI Programs Across Six Countries

This section presents six case studies of LTCI programs from Japan, Germany, South Korea, the Netherlands, Taiwan and Washington State.

The programs in Japan, Germany and South Korea are examples of traditional LTCI programs, primarily funded through social contributions and guaranteeing a specified level of service and financial coverage in return. These three programs have also evolved since being originally implemented. Specifically, Germany and Korea have increasingly focused on delivering LTC services at home and in the community compared to Japan, which still prioritizes the provision of institutional care.

The three remaining jurisdictions examined — the Netherlands, Taiwan and Washington State — have developed more unique examples of LTCI programs. The Netherlands' national LTCI program is integrated into their national health insurance program. Taiwan's national LTCI program is funded primarily through taxation generated from tobacco sales and the program is delivered through a network of care providers that focuses on enabling ageing in place. Washington State is the first jurisdiction in the United States (US) to implement a publicly funded, state-wide LTCI program. The program provides a lifetime benefit amount, providing recipients with a high level of autonomy over the type of care they receive. It is important to note that the US state of California also established a task force in 2019 to explore the possibility of developing and implementing a publicly funded state-wide LTCI program.[49] However, only the feasibility of potential options has been reported thus far, while financial analyses are currently being conducted around these options.[50]

Japan

In 2000, Japan introduced its national LTCI program in response to increasing out-of-pocket health expenditure for older adults, rapid population ageing and a change in family norms. In 2000, the proportion of the population aged 65 years and older was 17% and has since increased to 28% in 2020.[51] In 2015, five million people aged 65 years and older were eligible and receiving LTCI benefits from the LTCI program.[52]

Japan introduced the Long-Term Care Insurance Act in 1997 to address the rising costs of medical care among older adults and the declining number of families living with their parents as they age.[53] The national LTCI program consolidated Japan's social welfare and medical systems. Prior to introducing its national LTCI Program, Japan's welfare system covered selected LTC services, offering little in terms of client choice and financial protection against the costs of LTC. While the medical system encouraged LTC services to be delivered in hospitals, it lead to high rates of readmission and rising public expenditures.[54]

The Long-Term Care Insurance Act was officially enforced in 2000, launching Japan's LTCI program. The LTCI program has five objectives: spread the burden of paying for LTC for the older adults throughout society; establishing a clear link between contributions and benefits to clarify the sources of funding for the program; introducing a system under which health care services and LTC services are integrated but funded separately; adopting a social insurance scheme in developing a LTC program; and eliminating hospitalization for social purposes.[55]

Municipal governments were made responsible for administering LTCI in Japan, which includes determining recipient eligibility, setting premiums, and licensing providers, due to previous investment in LTC infrastructure and capacity at the community level throughout the 1990s. The LTCI program establishes "care managers" who are responsible for assisting eligible individuals in creating a personalized care plan and connecting them with the appropriate care providers. The national government is responsible for setting the rates and fees used to contract services providers, which are updated every three years. The fee rate is determined by the location of care (institutional or home) and the level of client need.[56]

A client's eligibility to be covered under the national LTCI program is determined by their care needs. Eligibility for national LTCI in Japan is not universal. Individuals must be in one of two age groups in order to be eligible for benefits: (1) adults aged 65 years and older, and (2) adults aged 40 to 64 years old. All adults aged 65 years and older are eligible to receive LTCI benefits irrespective of their income level and the availability of unpaid care provided by their family members. Adults aged 40 to 64 years are eligible to receive LTCI benefits if they have specific disabilities that are attributable to age-related diseases (such as dementia).[57]

Eligibility and the level of care provided through the LTCI program is determined using a 79-question survey conducted by a local government employee. The

questionnaire categorizes individuals into one of seven care levels that correspond to a specified amount of service and financial coverage. Individuals classified into care levels one to five are eligible to receive institution-based services, in-home services and community-based services. Individuals classified into the two remaining "support levels" are eligible to receive preventative LTC and community-based services.[58] Currently Japan's national LTCI program favors institutional care over home care, as benefits are only provided in-kind and not through direct cash benefits to family caregivers.

Japan's national LTCI program is primarily financed through social insurance contributions with supplemental revenue generated from general taxation. Social insurance contributions and taxation is collected from all levels of society, with administrative levels and certain groups responsible for a specified proportion of funding. Specifically, the national government funds 25% of the LTCI program; 12.5% is funded by the prefectural government; 12.5% is funded by the municipal government(s); 17% is funded by the insured aged 65 and older; and 33% is funded by the insured aged 40-64 years old. For adults aged 65 years and older, revenue is collected through premiums deducted from their pensions. Premium amounts are determined by local municipalities and vary depending on an individual's income. Adults aged 40 to 64 pay an additional premium with their contribution to the National Health Insurance (NHI) program (deducted from pay), which is pooled at the national level. Unemployed individuals must enroll in the national health insurance (CHI) program and apply to receive LTCI benefits.[59]

Multiple studies demonstrate a significant increase in formal care users among disabled older adults immediately after the introduction of LTCI in Japan – from 52% in 1998 to 74% in 2002.[60] Moreover, family members cared less for individuals after the introduction of LTCI. Only family members in the highest income groups were found to work more.[61] In terms of financial protection, there was a 5% reduction in household spending on LTC four years after the LTCI began, although there are increasing concerns around rising premiums. For example, premiums from 2000 to 2002 were ¥3,300 ($34 CAD), but estimated to be ¥4,300 ($45 CAD) from 2003-06 and ¥6,000 ($63 CAD) from 2012-14.[62]

Germany

In 1996, Germany introduced its LTCI program. The proportion of the population aged 65 years and older was 16% in 1996, increasing to 22% in 2020.[63] In 2016, there were approximately 2.7 million LTCI beneficiaries, nearly 70% of which received care at home.[64] Germany's national LTCI program aims to relieve the financial burden of long-term disability and illness and complement its pre-existing welfare infrastructure. The addition of an LTCI program to the welfare system was based on the overarching principle of solidarity — where society is considered responsible for providing a decent level of support for its members through collective actions.

Germany's national LTCI program is organized through German Sickness Funds (Health Insurance Funds). Each sickness fund is responsible for collecting social insurance contributions and contracting health services. There are approximately 600 sickness funds in Germany. Sickness funds operate as non-for-profit agencies that compete against each other, therefore incentivizing provider choice and quality. Upon the implementation of Germany's national LTCI program, each sickness fund had to create an LTC agency. The LTC agencies are responsible for collecting revenue, general management of the program and contracting care providers. Contracted providers of LTC services can be non-profit or for-profit operators. Currently only 1% of home care providers and 36% of LTC home providers are publicly operated.[65] Each sickness fund is responsible for representing its recipients and ensuring that all individuals have access to the benefits and care they need. Sickness funds, therefore, negotiate contracts with service providers, which are heavily influenced by performance and quality.[66]

The only eligibility requirement is that individuals require LTC services for longer than six months. Age is not a factor in determining eligibility. There are five levels of care based on need:[67]

- Care Level I - minor impairments of autonomy or skills
- Care Level II - considerable impairments of autonomy or of skills
- Care Level III - serious impairments of autonomy or of skills
- Care level IV - severe impairments of autonomy or of skills,
- Care level V - most severe impairments of autonomy or of skills.

Eligibility and the Care Level required is determined through an assessment of six areas of daily living (mobility, cognitive and communication skills, behaviors and psychological problems, self-sufficiency, coping with and independent handling

of illness or therapy-related requirements and charges, and organization of everyday life and social contacts). Based on the evaluation of the six modules, it is classified into five levels, with Care Level 1 being minor impairments of independence or skills and Care Level 5 being the most severe impairments of independence or the skills with special requirements for nursing care (Social Code (SGB) Social LTCI 11 – 15).[68]

Eligible LTCI recipients may receive their benefits in a LTC home or at home. One of the overarching goals of Germany's national LTCI program is to prevent unnecessary institutionalization by providing disease prevention, rehabilitation and care services at home whenever possible. In fact, the program does not cover the cost of room and board in institutional care settings. Recipients have the choice of receiving three types of payment: cash payments for informal caregivers; formal care services at home (payment direct to providers); and institutional care services (payments made to institutions). The size of benefits received are determined by eligibility and the choice of payment selected. For example, cash payments for informal care at home are set at half the formal and institutional payment levels. For institutional care, individuals are expected to co-pay for the costs of LTC services, although it is fixed based on an individual's levels of care need.[69] Care homes are responsible for determining the level of co-payment. In 2017, the average co-payment was €587 EUR ($859 CAD) per month.[70] In 2018, the allowances for care level I include a €125 EUR ($183 CAD) in-kind benefit to purchase LTC services, in addition to other allowances to improve living environments. Levels II to IV are eligible to receive (from levels II to IV): €316 EUR ($462 CAD), €545 EUR ($798 CAD), €728 EUR ($1,065 CAD), €901 EUR ($1,318 CAD) per month and benefits in kind for professional home care: €689 EUR ($1,008 CAD), €1,298 EUR ($1,899 CAD), €1,612 EUR ($2,359 CAD), €1,995 EUR ($2,919 CAD). In addition, beneficiaries classified to levels II to IV are eligible to receive a care allowance for six weeks per year, short-term care in care homes of up to eight weeks per year, and day and night care benefits.[71]

Germany's national LTCI program was added to the pre-existing health and welfare system and is primarily financed through social contributions. Employers and employees are mandated to contribute an equal amount to health, LTC, pension and unemployment insurance. At the beginning of the program, 1.7% of individuals' gross income, half paid by the employee and half by the employer (0.85% each), was paid directly to the national LTCI program fund. Pensioners contribute to the national LTCI programs by paying premiums out of pocket, and half is paid

on behalf of their insurance fund.[72] The unemployed contributions are made by the federal employment agency.[73] Germany ran a surplus of funds generated for their national LTCI program during the program's first several years. However, the demand for LTCI services eventually increased, resulting in the need for larger social insurance contributions from individuals' gross wages. For example, contributions had to be increased to 1.95% in 2013 and 2.35% in 2015, and 2.55% in 2017. The 2017 increase is expected to sustain and pre-fund the program until 2022.[74]

South Korea

In 2008, South Korea introduced its national LTCI program in response to its rapid population ageing and changing family dynamics. South Korea's national LTCI program aims to extend the average Korean's life expectancy; address increasing medical expenses for its older population; and support the changes in family functions and roles. In particular, South Korea's national LTCI program was designed to support declining filial piety by supporting family caregivers more economically.[v,75,76] In 2008, the proportion of the South Korean population aged 65 years and older was 10%, increasing to 16% in 2020.[77]

South Korea's LTCI program is an extension of its welfare programs which also includes national health insurance, pension plans, unemployment's insurance and workplace injury compensation programs.[78,79] South Korea's national LTCI program is governed at the national level by the Ministry of Health and Welfare (MOHW). The MOHW is responsible for overseeing all LTC programs and policies. Within the MOHW, LTCI is managed and operated alongside the National Health Insurance Service (NHIS). The NHIS collects revenue for both South Korea's national health insurance and national LTCI programs. The NHIS manages LTCI separately from health insurance, however, acting as a single insurer who is responsible for setting contributions, managing finances and overseeing services.[80,81]

LTC homes and providers are contracted by the NHIS to provide LTCI services. The provision of LTC services is carried out by a mix of public and private providers – with no care management system. Therefore, the LTCI operates in a highly market-oriented environment.[82] Throughout the national LTCI program policy formulation and planning processes, the South Korean government recognized it had limited public capacity and infrastructure to solely deliver a

[v] "Filial piety" is defined as: "is an attitude of respect for parents and ancestors in societies influenced by Confucian thought. Filial piety is demonstrated, in part, through service to one's parents. It has shaped family caregiving, intergenerational equity, old age income support, living arrangements, and other aspects of individual, family, social, political, and legal relations."

national LTCI program. The government, therefore, incentivized its private sector to invest in the LTC market, increasing the supply of private infrastructure and providers. More recent efforts have focused on shifting care to the community through integrated housing, health care, nursing care and support within the community.[83] Also, the MOHW is planning to implement a care management and integrated judgment system that manages and follows the beneficiary from assessment onwards.[84]

Eligibility to receive LTCI benefits is determined fully by an individual's care needs. Potential recipients are assessed for eligibility using a 52-question assessment of functional limitations, which classify individuals into five levels of physical or mental care needs, determining the total amount of service and financial coverage.[85]

Grade 1 is the highest level of care needed, with the person requiring assistance entirely for their daily life due to a mental or physical condition. Grade 4 is the lowest of care needed, with the person needing a certain extent of help for their daily life due to mental or physical condition. Grade 5, which is specific to individuals living with dementia, was added to expand coverage eligibility in 2014.[86] An additional "cognitive support" grade was added in 2018 to expand support for all beneficiaries living with dementia, regardless of the extent of the disease.[87,88]

Recipients are eligible to receive services provided in institutional facilities, home care services and family care allowances. Individuals can choose between receiving in-kind benefits for institutional care or cash benefits for home-based care.[89,90] Types of payment to providers include pay per hour for home care, pay per visits for home care nursing, and pay per day for institutional care or evening / day care.[91,92] Beneficiaries must provide a co-payment of 20% of the institutional benefit and 15% of the home care benefit.[93,94] Certain groups including people who are low-income may have their co-payment reduced or exempted. For example, recipients of the National Basic Living Security Act may be exempt from co-payments if their income is 30% or less of the median income.[95,96]

Revenue for South Korea's national LTCI program is predominantly generated from social insurance contributions. Both health and LTCI insurance are financed through separate compulsory contributions deducted off of an employee's wages, and employers share 50% of the costs with their employees. Self-employed persons are required to pay their contributions out of pocket. As previously mentioned, funds are collected and pooled by the NHIS. Overall, the NHIS is responsible for generating and contributing 60 to 65% of the total

revenue. Central and local government subsidies subsidize 35% of the cost LTCI costs. The remaining funding is generated from co-payments (15% of costs for institutional care recipients and 20% of costs for home care recipients). Selected groups, including low-income individuals, are eligible for reduced or exempted co-payments.[97]

The Netherlands

In 1968, the Netherlands introduced its national health insurance program, which covered the provision of LTC services. Thus, the Netherlands national LTCI program has been integrated into their national health insurance program, providing individuals with a guaranteed level of service coverage and financial protection for LTC services since 1968.[98] In 1968, 9.8% of the Dutch population was aged 65 years and older, increasing to 20% in 2020.[99]

The Netherlands national LTCI program is governed by the national health social insurance fund, governed by The Dutch Exceptional Medical Expenses Act (AWBZ).[100] The AWBZ is responsible for collecting insurance premiums and allocating funds to regional governments.[101] In an effort to reduce government spending on LTC, the administrative responsibilities of the LTCI program were transferred to the regional government offices. Regional offices receive an annual fixed budget from the AWBZ fund, which is used to contract and pay providers for the services covered under the national LTCI program. Under law, care providers are permitted to operate on a for-profit or not-for-profit basis.[102]

Eligibility to receive LTCI benefits is based purely on the person's health status and care needs and is determined by a national organization called the Center for Needs Assessment (CIZ). The services covered are classified into six categories: personal care; nursing care; supportive guidance; activating guidance; treatment; and accommodation. For example, household services, medical aids, home modifications, preventative mental health care, transportation and other assistance are all covered under the national LTCI program.[103] Individual co-payments are calculated depending on each recipient's care needs, level of income, household situation and age. The maximum co-payment per month is €2,332 EUR ($3,411 CAD).[104] Eligibility for LTCI benefits is not means-tested, meaning lower-income do not receive co-pay deductions or exemptions.[105] People with chronic conditions are eligible to receive an additional cash benefit to supplement the costs of living with such a condition.[106]

LTCI recipients have a high level of personal choice and autonomy around the benefits they receive. The LTCI program initially covered home care,

LTC home care and long-term hospital admissions. Service coverage has since been expanded to include home health care, ambulatory mental health care, family care and residential care for older adults. Beneficiaries can choose to receive the benefits through the provision of in-kind services or a personal budget (cash transfer), which are pro-rated at 75% of the institutional care costs. The Monitor Langdurige Zorg, which provides LTC data in the Netherlands, noted that the average personal budget beneficiary received €20,000 EUR ($29,256 CAD) in 2016.[107] LTCI recipients who choose to receive benefits through a personal care budget are free to choose who should deliver their care; including formal institutional care or home care delivered by a family member or friend.[108]

In 2015, the Netherlands passed the Long-Term Care Insurance Act, which separates public LTC and health financing. The new national LTCI program is primarily financed through social contributions. Each Dutch citizen aged 15 years and older with a taxable income now pays a contribution, paying a fixed premium of their wages or benefits. In 2017, the contribution rate was set at 9.65% of an individual's income up to a salary of €33,791 EUR ($49,419 CAD).[109] If one is not employed on a salaried income basis, individuals are responsible for paying the premiums themselves.[110] Income-related social contributions account for 68% of the total LTCI financing. The remaining financing comes from general taxation (24%) and co-payments (9%).

Several policy initiatives led to the establishment of a national LTCI program in Taiwan. Population ageing has been a longstanding concern in Taiwan, and as of 2020, 14% of the population was aged 65 years and older, with 20% of the population expected to be aged 65 years and older by 2026.[111] In 2007, the national government introduced a 10-year plan to implement a national LTCI program, known as LTC 1.0, which would be funded primarily through social insurance contributions. However, the political party in power at the time lost the election in 2016. The new political leadership opposed the use of social insurance contributions to finance LTC 1.0. The new government dropped the LTC 1.0 program and proposed a new plan for a national LTCI program, calling it LTC 2.0. LTC 2.0 generates revenue through increases in estate, gift and tobacco taxation instead of social contributions.[112]

LTC 2.0 expanded the level of service and financial coverage provided through LTC 1.0. LTC 2.0 has five main objectives: to develop high-quality, fairly priced, and universal LTC services to put ageing-in-place values into practice; support families through multiple types

of care; extend service coverage to include preventative care; and generate community services and home-based medical care.[113] LTC 2.0 was specifically designed to address shortages of LTC workers and an inadequate supply of services that focused on supporting the rapidly ageing population to age in place.[114]

The administration of LTC 2.0 is decentralized to local and community governments.[115] Management and organization begins with a LTC management center. LTC management centers are connected to a larger network of care providers within the communities, who offer a variety of services based on each individual care needs.[116] Under the Government Procurement Law, LTC services must be provided under the public sector. Only if the required care is too complex or timely may the services be contracted to the private sector.[117]

The community provider network is tiered into the three layers known as the "ABC" system.[118] Care managers are responsible for co-ordinating and managing the care of individuals in the ABC system. In part "A" care managers evaluate individuals and determine their care needs and eligibility for benefits, develop individualized care plans, and connect them to service providers within the network of care. Part "B" is the actual delivery of services in the system and is the responsibility of service providers in the network. Part "C" is the responsibility of both care providers and the care manager, in which they actively search for ways to keep beneficiaries engaged in the community.[119] Care managers are also responsible for continuously monitoring the quality of care being provided to individuals.[120]

LTC 2.0 expanded its population eligibility by lowering the age of eligibility to 55 years of age and targeting high-risk groups.[121] High-risk groups eligible to apply include disabled Aboriginals aged 55 years and older; people living with dementia aged 50 years and older; adults who are frail and living alone in need of assistance; adults with disabilities impacting ADLs who are aged 65 years and older. Eligibility is determined by care managers who assess individuals using a comprehensive ADL assessment tool. The ADL assessment was expanded to include assessments of cognitive impairment and special care needs as a part of the LTC 2.0. LTC 1.0 also provided limited population coverage, targeting people specifically with disabilities.

LTC 2.0 covers 17 services focused on creating a continuum of integrated care that supports older adults to live in their communities. The expanded services include dementia care, Aboriginal community-integrated services, small-size multiple-function centers (connecting adult daycare, respite care and others),

multiple support services for family caregiver centers, a community-based integration care system, community health preventive care, preventive and delaying disability programs, links to discharge plans from hospitals, and links to home-based medical care.[122]

Payment is based on four factors: personal services; professional care; transportation; and home modifications. The total level of financial coverage ranges on need, type of services provided and the ability to pay. Individuals receiving personal and professional care NT$334 to NT$1,206 TWD per month ($15.00 to $54.17 CAD); coverage for transportation ranges from NT$56 to NT$80 TWD per month ($2.52 to $3.59 CAD); coverage for assistive devices is up to NT$1,333 per month ($59.87 CAD); and coverage for respite care for family caregivers ranges from NT$1,078 to $1,617 per month ($48.42 to $72.65 CAD). Fees beyond the coverage limit are paid out-of-pocket by the individual receiving care and people in low-income groups are exempt from paying individual premiums.[123]

Washington State

In 2019, Washington State passed a LTCI benefit in response to the low ability of people to pay for LTC services amongst its rapidly ageing population. The LTCI program, titled WA Cares Fund, is to be financed through social insurance contributions, which will deduct $0.58 USD per $100 USD of an individual's earnings.[124] Employers are not required to contribute premiums to the LTCI program, although they are responsible for collecting LTCI premiums from their employees. Workers may apply for an exemption to premiums if they are aged 18 years or older and had purchased LTCI before November 1, 2021.[125]

Eligibility to receive benefits extends to anyone aged 18 years or older who is determined by the Department of Social and Health Services to be needing assistance with at least three ADLs. If an individual has contributed premiums for either (a) for 10 years without an interruption for five of those years and worked at least 500 hours during those 10 years; (b) for three years within the last six years, and worked at least 500 hours during each of the three years, then they are eligible to receive LTCI benefits.[126] Eligible residents are entitled to receive

up to a lifetime maximum allowance of $36,500 USD ($50,200 CAD), which is adjusted annually for inflation.[127] The benefits can be spent on a wide range of services, including both in-home and institutional care. The program is designed to promote ageing in place and can be used to purchase home modifications, adaptive equipment and technologies, home-delivered meals, in-home personal care, training for non-professional caregivers, respite care, and compensate family caregivers. The lifetime benefits of $36,500 USD ($46,887.9 CAD) is estimated to provide up to five years of respite care, one year of part time or in-home care, eight to 12 months of assisted living, six to eight months of an adult person's family home care,[vi] and four to six months of care in a skilled nursing facility such as a LTC home. Annual estimated Medicare program savings are estimated at $19 million USD ($26.1 million CAD) in the first year of the LTCI program, and up to $440 million USD ($605 million CAD) by 2050.[128]

The program was planned to begin collecting premiums in January 2022 and providing benefits from January 2025.[129] However, due to the issues raised with coverage gaps,[130] the program's implementation has been delayed by 18 months, whereby premiums will begin to be collected in July 2023 and benefits will start to be provided in July 2026.[131] Two government bills were signed in January 2022 regarding program changes,[132] with the first (House Bill 1732) noting the delayed implementation plan and allowing those who are near retirement to receive partial benefits based on the number of years premiums were paid. For each year of premium payments (minimum 500 hours), the individual will receive 10% of the maximum benefit.[133] The second (House Bill 1733) allows certain groups who may not be able to benefit from the program to opt out from contributing premiums. The groups noted in this bill are: workers on temporary non-immigrant visas, spouses or registered domestic partners of active-duty service members, veterans with a service-connected disability of at least 70%, and employees who live in a different state.[134] Currently, the commission associated with the WA Cares Fund is studying how to accommodate workers who plan to retire out of state.[135]

[vi] "Adult Family Homes: These are residential homes licensed to care for up to six non-related residents. They provide room, board, laundry, necessary supervision, and necessary help with ADLs, personal care, and social services."

Washington State Department of Family and Social Services. (n.d.). About adult family homes. Retrieved March 28, 2023, from: https://www.dshs.wa.gov/altsa/residential-care-services/about-adult-family-homes

Part 3: Six Lessons Learned From Other LTCI Programs Created to Date

This section presents six lessons that the creation of the LTCI programs from Japan, Germany, South Korea, the Netherlands, Taiwan and Washington State should allow us to consider.

Lesson 1: There is no "one-size fits all" approach to LTCI programs

The six LTCI Case Studies from Japan, Germany, South Korea, the Netherlands, Taiwan and Washington State provide a template on how a national LTCI program could be designed to suit the Canadian social and political context; however, each of the existing LTCI programs evaluated is uniquely designed to address the challenges associated with population ageing. There is not a "one-size-fits-all" approach to national LTCI programs as they differ in their objectives, benefits, eligibility, organizational structure and financing arrangements.

Germany, the Netherlands, South Korea and Washington State provide coverage for their LTCI services. Eligibility is determined by individual care needs, and age is not a requirement to access services. Washington required a deductible where individuals contribute a certain amount for a certain length of time before they are eligible to receive benefits. In comparison, recipients must be a certain age to receive LTCI benefits in Japan and Taiwan. To be eligible to receive LTCI benefits in Japan, an individual must be aged 65 years and older, or be aged 20 to 64 years of age and require high levels of care. Taiwan requires individuals to be aged 55 years and older and be in a specified high-risk group.

Across all national LTCI programs, eligibility is determined by an evaluation that assesses an individual's ability to perform their ADLs, along with physical and cognitive limitations. These assessments place individuals into "levels" based on the complexity and type of care required. Each care level has a corresponding level of financial protection. For example, Japan uses a 79-question survey conducted by a municipal official to determine an individual's care needs. Individuals are then placed into one of seven care levels, determining the level of service and financial coverage provided under the LTCI program. South Korea uses a similar 52 question survey which classifies individuals into one of five levels of physical or cognitive care needs.

The comprehensiveness of service coverage is relatively standard across national LTCI programs, with the exception of the Netherlands. Japan, South Korea, Germany and Taiwan all cover the costs of care, whether delivered in an LTC home, the community, or at home. Service coverage in the Netherlands extends to additional services such as mental health, home modifications and care aids. Regardless, countries are constantly evolving the services covered under their national LTCI programs. For example, South Korea recently added two additional care classifications for clients living with dementia. Japan recently added two additional care levels for individuals who are ineligible, allowing them to access preventative services.

Lesson 2: LTCI programs are being implemented at varying stages of national demographic transitions

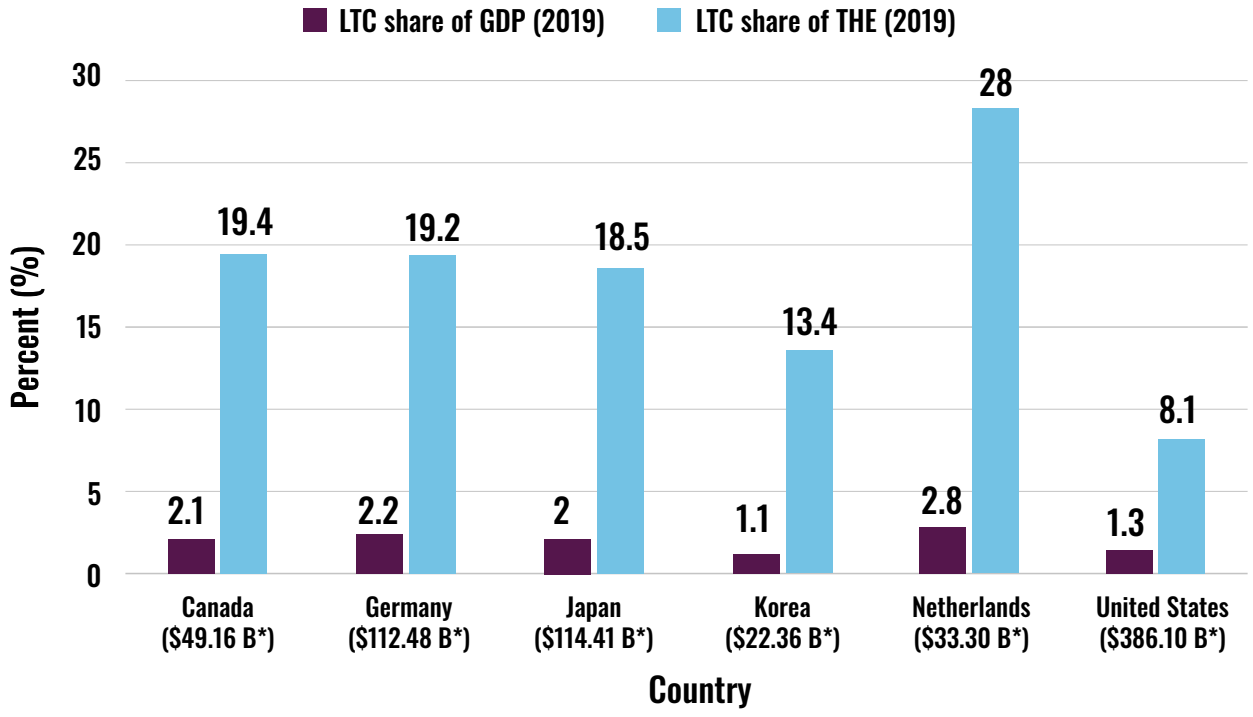
Each national LTCI program examined in this paper was implemented at varying stages of its home country's demographic transition. South Korea (10% aged 65 years and older) and the Netherlands (9.8% aged 65 years and older) implemented their LTCI programs relatively early in their demographic transitions compared to the other comparator countries. Specifically, South Korea proactively implemented a national LTCI program to address the increasing demand for LTC services associated with population ageing and changing cultural norms. Japan (17% aged 65 years and older) and Germany (16% aged 65 years and older) both implemented national LTCI programs at a later stage of their demographic transitions, primarily due to alleviate the financial burden of paying for LTC. The timing of implementation in Germany and Japan mirrors the current demographic context of Canada, as 19% of Canadians are now currently aged 65 years and older.[136]

Lesson 3: LTCI programs are not a cost-saving alternative, but rather serve a mechanism for guaranteeing a specified level of service coverage and financial protection

It is important to understand that national LTCI programs are not designed to reduce the overall costs associated with the provision of LTC services. Instead, a national LTCI program addresses rapid population ageing and its associated increasing demand for LTC services. This thereby provides a specified level of individual and system level financial protection against LTC costs, and expands or complements the welfare system of a country (although Washington State anticipates significant savings for its Medicare health insurance program).[137]

Figure 3 shows, based on the latest OECD data[vii] available from 2019, that Canada spends a lower proportion of its GDP on LTC health services per year (2.1%) compared to the Netherlands (2.8%), while spending a similar proportion to Japan (2.2%) and Germany (2.0%) and a much greater proportion than South Korea (1.1%) and the US (1.3%). Similarly, Canada also allocated a lower share of its annual total health expenditure (THE) towards LTC health services (19.4%) compared to the Netherlands (28%), while allocating a similar proportion to Germany (19.2%) and Japan (18.5%) and much more than South Korea (13.4%).[138] All of the countries presented spend a greater proportion of share THE on LTC health services compared to the US (8.1%).[139]

Figure 3: Gross Domestic Product and Total Health Expenditure Allocated to LTC Health Services in Selected OECD Countries



* All national spending are noted in CAD.

Data from OECD.[140]

[vii] Taiwan and Washington State are not OECD countries and do not have comparable data. Data for the United States has been provided in reference to Washington State.

Whether the introduction of a national LTCI program increases or decreases expenditures is outside of scope for this paper. Understanding the dynamics of policy changes affecting diverse programs and populations is a complex task that requires sophisticated tools and models so as to evaluate the financial trade-offs and consequences. Such an analysis would need to take into explicit account, interdependencies within provincial and territorial LTC programs and the provision of unpaid care by caregivers, as well as Canada's broader tax and social transfer systems and current retirement income system, which is a complicated system of financial flows that follow prescribed tax and benefit rules with separate components that are intimately connected and interdependent, all in the context and backdrop of a dynamically changing population.

The purpose of this lesson is simply to stress that a national LTCI program would serve as a means of offering a guaranteed level of financial protection against the individual's costs associated with having to pay for their LTC services.

Lesson 4: LTCI programs can be deliberately tailored to target national specific needs and goals

More specific sub-objectives help to distinguish between each country's national LTCI program. Germany, South Korea and Taiwan's national LTCI programs emphasize the provision of home and community-based LTC services, aiming to reduce unnecessary institutionalization. For example, 70% of LTCI beneficiaries in Germany receive care at home, and one of Taiwan's LTCI goals explicitly aims to put ageing-in-place principles into action. Comparatively, Japan's national LTCI programs emphasize institutional care by only providing in-kind benefits to providers, which perhaps explains why there is a higher rate of institutional LTC provision in that country. The national LTCI programs in the Netherlands and Washington State focus on individual autonomy by allowing beneficiaries to select and purchase care attuned to their own preferences with little interference or restrictions.

How benefits are received reflects each LTCI system's sub-objectives. There are three ways that LTCI benefits can be provided: in-kind payments directly to formal institutions and care providers, in-kind payments to home care providers, or cash benefit allowances. With the exception of Japan, each national LTCI program permits benefits to be paid in all three ways. In Japan, all benefits are paid from a municipal agency directly to formal care providers. Benefits can also be paid as cash transfers directly to the beneficiaries or their care providers. Beneficiaries have autonomy to spend the cash on the services they need, or they can be used to support a family caregiver.

This is most evident in the Netherlands, as those who choose to receive their benefits in cash transfers receive an average €20,000 EUR per year ($29,283 CAD). The rate of the cash benefits is usually provided below the rate of an institutional care provider. Germany and South Korea allow individuals to choose between the delivery method, paid in-kind directly to the care provider, or through cash transfers to caregivers. In Washington State, individuals are entitled to receive a lifetime maximum of financial assistance of $36,500 USD ($50,230 CAD) for LTC services. Individuals have full autonomy to spend their funds on their choice of LTC services.

Another important dimension of national LTCI programs has been the establishment of care plan managers at the municipal level in South Korea, Japan, Germany and Taiwan. Care plan managers act as gatekeepers to the LTCI program. They are responsible for assessing the eligibility of individuals for LTCI benefits and coordinating care plans with beneficiaries. This includes developing a care plan and ensuring that each beneficiary has access to the necessary services. In Taiwan's ABC system, care managers are also responsible for ensuring that beneficiaries have opportunities to engage and participate in their communities.

Lesson 5: LTCI programs can be adapted and integrated from existing social welfare and LTC infrastructure

The national LTCI programs of countries examined were commonly integrated into the pre-existing organizational and physical LTC infrastructure. For example, Germany, South Korea, Japan and Taiwan are all governed through pre-existing centralized agencies (such as insurance organizations), which were expanded to accommodate the implementation of a national LTCI program. For example, in South Korea, the MOHFW is responsible for policy and programming, while the NHIS is responsible for revenue collection and allocation. These two organizations operate at the national level and existed prior to the implementation of the national LTCI program. Local and regional governments are typically responsible for assessing client eligibility and contracting service providers. One exception to the governance and organization of the national LTCI program is the Netherlands. The Netherlands' national LTCI program is integrated into its national health insurance program, meaning LTC services are covered under its national health insurance program.

Nearly all countries have allowed for public and private providers and operators to deliver services for its LTCI programs. In the decade before implementing its national LTCI program, Japan invested heavily into developing the infrastructure and capacity for its LTC system at the municipal level. South Korea, for example, heavily incentivized the development of its private LTC sector over the decade before implementing its national LTCI program. These investments were instrumental in implementing a national LTCI program, as the public sector lacked the capacity to deliver such a program. Taiwan also stands out as it only permits LTC services to be contracted to private providers if public providers cannot provide the services in a timely manner.

Lesson 6: LTCI programs can be designed through a number of funding mechanisms

LTCI programs are typically distinguished by their predominant funding mechanism, either through social insurance contributions or general taxation. Social insurance contributions, where a predetermined amount is deducted directly from a wage, is the predominant method for financing national LTCI programs in Germany, Japan, South Korea, the Netherlands and Washington State. Taiwan is the only LTCI program that is primarily funded through general taxation revenue. Beyond social contributions and general taxation, revenue is also generated through premiums. Premiums are typically collected at the point of service or where eligible populations pay an additional contribution for utilizing LTCI benefits. Another important dimension in financing programs is via ensuring the risks and costs of administering a LTCI program are spread across a national population. Japan and Germany both specify the contributions made by society, including national governments, local governments, insurance agencies and the individual. Moreover, South Korea and Taiwan exempt lower-income and high-risk populations from premiums, further increasing the equity of their national LTCI programs.

Part 4: Implications for Establishing an LTCI Program in Canada

The COVID-19 pandemic has amplified long-standing issues within Canada's LTC systems. Urgent action is required to adapt the provision of LTC services in Canada to better address the needs and preferences of older adults, along with current unmet needs and the growing future demands for care.

Establishing a national LTCI program in Canada could present a unique opportunity to re-imagine Canada's social contract and better align its provision of LTC services to the needs and preferences of older Canadians. A national LTCI program could help to more clearly establish an individual's expected contributions towards their future possible LTC needs, and the LTC benefits and financial level of protection that the state will provide in return. Specifically, a national LTCI program would require specific contributions from Canadians via social contributions from their wages or through general taxation. In return, Canadians would receive a guaranteed level of LTC services and financial coverage.

The current demographic context of Canada is equivalent to the proportion of adults aged 65 years and older in Germany and Japan at the time they introduced their own national LTCI programs. The overarching objectives for a national LTCI program will be important considerations for Canada, particularly as the overwhelming majority of Canadians desire to age-in-place, combined with the likely inability of LTC settings to keep up with the growing demands of its rapidly ageing population in coming years when already 52,000 Canadians are on its LTC home wait-lists,[141] and in addition close to 420,000 Canadian households estimated to have unmet home care needs.[142]

Establishing a national LTCI program could also present an opportunity to standardize LTC policies and programs across Canada. A national LTCI program could present a chance to establish a national definition of LTC services, creating common standards for eligibility, benefits, and the quality of care that Canada wants to commit to providing. Furthermore, standardizing the provision of LTC services nationally could help to greatly reduce fragmentation and lead to more equitable service coverage and financial protection. A common definition, and standards related to the provision of LTC services, could also have the potential to improve quality of care, local and national governance, priority setting, and resource allocation.

In theory, Canada may currently have the capacity to implement a national LTCI program. According to CIHI data, Canada has a total of 2,076 LTC homes as of 2021. Of its 2,076 LTC homes, 46% are publicly owned and 54% are privately owned (29% for profit, and 23% non-for profit).[143] In addition the financing mechanisms commonly used to generate revenue for national LTCI programs, payroll contributions and tax-based financing, are widely in use for the provision of other national programs. For example, payroll contributions are deducted from an individual's salary to fund the Canada Pension Plan (CPP). In comparison, Canada's national health insurance program is primarily financed through provincial, territorial and federal tax revenues. In terms of governance, Canada's provinces and territories are each responsible for administering their publicly-funded health care systems. A similar approach could be adopted for the provision of a national LTCI program, where revenues could be collected at the provincial and/or national levels. Specified levels of provincial revenue generated from taxation and/or payroll contributions could then be earmarked for an LTCI program. Meanwhile, revenue generated at the national level from payroll contributions and/or general taxation could be pooled and re-distributed to provinces based on health care needs, demographics and financing gaps.

The NIA has developed six key ideas that should be considered in the potential planning and implementing of a national LTCI program for Canada:

1. Present a national LTCI program as part of a new social contract for Canadians.

A national LTCI program could be politically advantageous as it can help to clearly establish the continuum between individual contributions and the benefits they receive in return, related to meeting their possible future LTC needs. A new social contract would ask Canadians to contribute a specific amount of their individual wages, and the provincial and federal governments would provide additional revenue generated from taxation. In return, all Canadians would be guaranteed a certain level of LTC service coverage and financial protection against their possible future LTC costs. Thus, a national LTCI program has the potential to build much-needed trust between individuals and their governments across Canada and foster a greater sense of security when it comes to meeting possible and unpredictable future LTC needs, especially when its already clear that current public funding levels alone have not been able to meet current LTC needs.[144]

2. Leverage the introduction of a national LTCI program to support Canadians to Age-In-the-*Right*-Place.

The COVID-19 pandemic reaffirmed that the overwhelming majority of Canadians desire to age in their own homes and communities. Canada's current LTC spending allocation is heavily favoured towards institutional care. Implementing a national LTCI program could have the potential to serve as a catalyst to re-organize and allocate LTC funding towards the greater provision of more home and community care. This is best exemplified in Germany, where approximately 70% of LTCI recipients receive care at home or in the community, and 54% of Germany's current LTC expenditure is on the provision of home and community care.[145]

3. Use a national LTCI program to standardize client eligibility and benefits, specifically drawing on lessons from the South Korean and German LTCI programs.

An individual's need for care is the only determining factor for LTCI eligibility in South Korea and Germany. Needs-based eligibility would ensure that all Canadians who need LTC services would have access to it, helping to address the high rates of unmet care. Both Germany and South Korea have adopted similar methods for assessing an individual's eligibility to receive LTCI benefits. These programs use a detailed questionnaire that assesses an individual's cognitive health and their ability to perform ADLs. The questionnaire score identifies the individual's care needs, placing them into a corresponding level of care. Each level of care has corresponding benefits and financial protection. Both South Korea and Germany allow individuals to choose between receiving benefits in-kind or as a cash allowance. It would be critical to ensure that Canada adopts such a flexible approach to receiving benefits. For example, both Germany and Taiwan also provide additional benefits for recipients to modify their homes in order to make it safer and more age-friendly.

4. Leverage Canada's established network of public and private LTC home and community care providers to operationalize a national LTCI program.

Canada's current LTC system consists of both public and private providers of home and institutional care. As in the case of Japan, South Korea, Germany and the Netherlands, standard monetary rates of care would need to be established by either the federal or provincial governments. Moreover, for a national LTCI program to be operationalized effectively in Canada, both public and private would need to be contracted to provide home and institutional care services. Having the government set the funded rates for contracted care providers would also be advantageous and help promote client choice and stimulate provider competition, leading to improved service delivery quality both at home and in institutions.

5. Establish care plan managers as the focal point of a national LTCI program to ensure that beneficiaries receive appropriate, timely care and have opportunities to remain engaged in their communities.

Germany, South Korea, Japan and Taiwan each established care plan managers as a part of their national LTCI programs. Care plan managers ensure that recipients are receiving appropriate care based on their needs. Their responsibilities, as in Taiwan, can also include ensuring that recipients of care have opportunities to remain engaged and active within their own communities. Overall, establishing care plan managers at local levels would help to ensure that the care being provided is meeting the actual needs of LTC recipients, and that recipients are included in decision-making around the provision of their LTC services and continue to have the opportunity to live more fulfilling lives.

6. Use social contributions as the primary funding mechanism for a national LTCI program, ensuring that revenue is reliable, sustainable and equitable.

Earmarked social contributions towards a national LTCI program would ensure that the program would receive a consistent level of funding. In addition, general taxation revenues collected from provincial and federal governments could be used to supplement the costs of the program. Individual premiums could be adjusted to ensure that low-income Canadians pay only a partial amount or are exempt from paying them. Funding the national LTCI program primarily through social insurance contributions, with supplemental financing from provincial, federal, and individual sources would redistribute and subsidize the costs of LTC across the entire Canadian population, which could lead to a much more highly equitable and sustainable national LTCI program and LTC systems. Regardless of the funding mechanisms under consideration, however, comprehensive analyses would be required to evaluate the implications within the current Canadian tax and transfer systems, so as to test for economic sustainability as well as to avoid unintended consequences such as major financial inequities and perverse financial incentives.

Part 5: Conclusion

Implementing a national LTCI program presents a range of benefits and could present a unique opportunity to strengthen Canada's LTC systems and their future abilities to meet the needs of its rapidly ageing populations. It's also an opportunity to re-imagine Canada's social contract with its citizens to better support and enable them as they age in their growing desire to Age-In-the-*Right*-Place. Moreover, a national LTCI program for Canada could have the potential to greatly improve the service and financial coverage, the quality of care, and equity around access to and the provision of LTC services, something Canada's pandemic experience has highlighted as long-standing challenges within Canada's LTC systems that need to be addressed.

The six LTCI program case studies examined in this report from Japan, Germany, South Korea, the Netherlands, Taiwan and Washington State each illustrate important considerations for the planning and implementation of a national LTCI program for Canada. While the introduction of a national LTCI program will likely not be a solution to the rising expenditures associated with the provision of LTC services, it could represent an opportunity to reduce fragmentation, guarantee all Canadians a basic level of service and financial coverage for LTC services, and create a more consistent and sustainable level of funding for LTC for future older Canadians.

A national LTCI program could also help to standardize the provision of LTC services across Canada, in the same way the CHA has done to help ensure a more consistent approach to the delivery of hospital and physician services, while also providing opportunities to improve the quality of care as well as monitoring and evaluation and the scaling up of best practices more easily at a national level.

Finally, as much of Canada's pre-existing infrastructure, including Canada's already established network of public and private LTC providers, governance of its federal and provincial health insurance programs, and revenue collection mechanism including social contributions from employees' wages and general taxation, could likely be leveraged to implement a national LTCI program.

As a first step, high-quality economic evidence and insights are needed within the Canadian context. The implications of policy reforms are rarely clear – particularly when it comes to Canada's Retirement Income System (RIS). This is because the Canadian RIS is an integrated and dynamic one, made up of complex tax and social benefits programs in which a change in one income flow can trigger

a complicated network of repercussions and financial trade-offs. Along with the complexity of the Canadian RIS is the complexity of the population itself, made up of people with highly diverse life courses. High-quality, comprehensive and holistic analyses will therefore be a necessary first step to understand and evaluate the trade-offs between alternative policy reform options within Canada's complex economic systems and health programs across its varied and evolving population.

While in theory, Canada may have the capacity to implement a national LTCI program, it first needs to determine if this would be the best way to help Canadians manage their future LTC costs. Regardless of whether publicly-funded LTC services continue to be funded in Canada through general taxation, a new social insurance program or another mechanism, it is very clear that additional forms of revenue will be needed to ensure appropriate annual LTC expenditures to better meet the needs of Canada's ageing population over the coming years.

Table: Key Characteristics of LTCI Programs Across Six Countries

LTCI Program Characteristics	Japan	Germany	South Korea	Netherlands	Taiwan	Washington State
Year Introduced	2000	1996	2008	1968	2007 (LTC 1.0) 2016 (LTC 2.0)	2019 (program created) 2022 (changes to program eligibility, exemptions, and start date) 2023 (premiums will start to be collected) 2026 (benefits become available)
Aims / Objectives	• Spread burden of paying for LTC across society • Establish clear link between contributions and benefits • Integrated health and LTC insurance services but separate funding • Adopt a social insurance scheme for funding LTC • Eliminate hospitalization for social purposes	• Relieve financial burden imposed by LTC disability and illness • Complement existing welfare infrastructure	• Extend life expectancy • Address increasing medical expenses for the older adults • Support changes in family functions and roles	• Reduce financial risk • Complement social health insurance system	• Develop high-quality, fair priced, universal LTC • Put ageing in place values into practice • Extent coverage to preventative care • Community and home-based medical care	• Relieve some of the financial burden imposed by LTC on workers as they age

Governance / Administration	• Municipal governments are responsible for determining client eligibility, setting premiums and licensing providers • Federal government responsible for setting fees used contract providers	• Organized through sickness funds (health insurance revenue collectors and operators) • Services are contracted to both public and private providers and operators	• Policies and programming governed centrally through the Ministry of Health and Welfare (MOHW) • Local governments approve, cancel, and supervise the installation of facilities. • National Health Insurance Service (NHIS) manages and operates LTCI, acting as an insurer	• Revenue collection and governance administered by Dutch Medical Expense Act • Administration responsibilities transferred to regional government offices	• Governance and administration decentralized to community level • Providers must be publicly operated • Network based care provision, managed through LTC management centers and care managers (ABC system)	• The Department of Social and Health Services, the Health Care Authority, the Office of the State Actuary, and the Employment Security Department are responsible for the implementation and administration of the program
Eligibility	• Eligibility determined by age and need. Two eligible age groups 1. 65 years and older 2. 40-64 years old and have specific age-related diseases • 79 question survey classifies individuals into five levels of need	• Age is not requirement • Must require LTC for longer than six months • Assessment of four ADLs (hygiene, eating, mobility, housekeeping) • Five levels of care need: • Care Level II - considerable impairments of autonomy or of skills • Care Level III - serious impairments of autonomy or of skills • Care level IIII: severe impairments of autonomy or of skills, • Care level IV: most severe impairments of autonomy or of skills.	• Eligibility to be determined by need • A 52 question survey classified individuals into five levels of care need (1 is highest, 4 is lowest) • Grade 5 and cognitive support is specific to dementia clients	• The Center for Needs Assessment (CIZ) determines eligibility based on health status and care needs	• Eligibility includes anyone aged 55 years and older and selected high-risk groups, including 1. Dementia clients 50 years and older 2. Adults who are frail and need living assistance 3. Disability with ADLs aged 65 years and older 4. Aboriginals aged 55 and older who have disabilities • Eligibility is determined using an assessment of ADLs along with cognitive impairment and special care needs	• A worker is qualified for the program if they have paid premiums (based on at least 500 hours of work per year) for the equivalent of: 1. A total of ten years without interruption of five or more consecutive years OR 2. Three years within the last six years • * A worker born before 1968, who do not meet the above requirements, can still become qualified if they have paid premiums for at least one year (minimum of 500 hours worked) • A qualified individual may become eligible to receive benefits if they require assistance with at least three ADLs

Benefits	• Services provided are determined by care classification level. 1. Levels 1-5 are eligible to receive facility, in-home, and community-based services 2. Two 'support levels' are eligible to receive preventative LTC and community services	• Beneficiaries can receive insurance for home and institutional care • Three types of payments options: 1. Cash for informal care 2. direct to provider for formal home care 3. direct to provider for institutional care	• Benefits include institutional care services, home care services, and family care allowances • Payments to provides include 1. Pay per hour for home care 2. Pay per visit for home care 3. Pay per day institutional care	• Six service categories are covered 1. Personal care 2. Nursing care 3. Supportive guidance 4. Activating guidance 5. Treatment 6. Accommodation • Can choose to receive benefits in kind or through a personal budget	• LTCI covers 17 services • Expanded to include dementia care along with community based Aboriginal care, respite care, preventive care, and day care	• The benefits can be spent on a wide range of family and professional care, including adaptations to the home to support ageing in place • These services must be within the state and from providers who are approved and contracted with the program • Payments will be sent directly to providers
Financial Coverage	• Premium amounts are determined by local municipalities and vary based on incomes. • Adults aged 40 to 65 contribute an additional social contribution which is pooled at the national level	• Cash payments to informal care are set at half the formal rate • Individuals are expected to cover 25% to 50% of institutional care cost	• Institutional care beneficiaries must copay 20% of the benefit • Home care beneficiaries must copay 15% of the benefit • Certain groups including low income may have their co-payment reduced or exempt	• A co-payment is required. It is dependent on the level of annual income, age and household size. • In year X, the maximum co-payment was EUR 2332	• Copayments are required based on individual's ability and the type of care providers (professional, transportation, home modifications, and personal services) • Fees beyond the upper limit of coverage are paid out of pocket.	• Lifetime benefits maximum of $36,500 USD (except for those receiving partial benefits, who will receive 10% of the maximum benefit for each year [min. 500 hours] premiums were paid)

Funding	Revenue generated from multiple sources: • 25% national government • 12.5% prefectural government • 12.5% municipal government • 17% by insured population aged 65 years and older • 33% by insured adults aged 40 to 65	• Revenue is collected through mandated social insurance contributions. • A total of 2.55% of employees income is paid directly to the LTCI (sickness fund)	• Revenue collected through compulsory social insurance contributions off of individuals wages • Social insurance contributions account for 60%-65% of all revenue • 20% of expected annual contribution by central government subsidies • Co-payment (institutional or home) funds	• Revenue collected through social contribution premiums, general taxation, and premiums • 68% funded by social contributions • 24% funded through general taxation • 9% funded through premiums	• Revenue is generated through general taxation from estate, gift and tobacco taxes • Co-payments are also required based on the services provided and ability to pay	• Funded through payroll deductions of $0.58 per $100 of workers' earnings

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